Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

SIERRA PROVIDENCE PHYSICAL REHAB HOSPITAL
C/O THE LAW OFFICES OF P MATTHEW ONEIL
6514 MCNEIL DR UNIT 1
AUSTIN TX 78729-7720

Respondent Name
TASB RISK MANAGEMENT FUND

Carrier's Austin Representative Box
Box Number 47

MFDR Tracking Number
M4-09-4671-01

MFDR Date Received
December 19, 2008

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "the claimant in this case was admitted and received inpatient hospital procedures. . . The procedure involved physical rehabilitation therapy, surgery, supplies, and pharmaceuticals. Fair and reasonable payment for this claim should be at 75% of the Hospital's charges, as the amount billed was over the $40,000 minimum stop-loss threshold. . . . It is somewhat unclear on what the Carrier's payment is based. . . . For the 'per diem' paid, the Carrier alleges that per diem is based on its 'fair and reasonable' reimbursement methodology, whatever that may be. The Carrier also alleges it is paid pursuant to a negotiated rate. This is not true and is incorrect. Thus, the method under which the Carrier paid the claim is unclear and unsupported."

Amount in Dispute: $50,718.15

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The provider's services in this dispute is a rehabilitation facility. The requestor's rationale for Increased Reimbursement or Refund as well as the accompanying letter make reference to rule 134.401(c)(6), which is for acute care inpatient facilities exceeding $40,000.00 in charges . . . As such, their reason for dispute is not valid as a basis for the dispute. . . . Fair and reasonable has been left to be determined by the carrier. . . . The new rule (134.404) effective March 1, 2008 also does not give direction on payment rates for rehabilitation facilities. It continues to be a carrier determined amount. . . . Since there is no allowable amount set by DWC for rehab facilities . . . negotiations are done with the facility as a matter of course to come to an agreement on reimbursement of their services. Since Paul Hymel, a representative of Sierra Providence agreed to accept $485.00 a day, TASB feels the agreement should be honored. . . . Documentation showing there was a statement by Paul Hymel of Sierra Providence that the SNF level was $485.00 a day is enclosed."

Response Submitted by: TASB Risk Management Fund, 12007 Research Blvd., Austin, Texas 78759-2439

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
February 11, 2008 to March 27, 2008	Rehabilitation Hospital Services	$50,718.15	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.1 provides for fair and reasonable reimbursement of health care in the absence of an applicable fee guideline.
3. 28 Texas Administrative Code §134.401 sets out the former fee guideline for acute care inpatient hospital services.
4. 28 Texas Administrative Code §134.404 sets out the guidelines for reimbursement of hospital facility fees for inpatient services.
5. Texas Business and Commerce Code §26.01 sets out requirements for agreements and contracts.
6. Texas Labor Code §413.011 sets forth provisions regarding reimbursement policies and guidelines.
7. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - W1 – Workers Compensation State Fee Schedule Adjustment
   - W4 – No additional reimbursement allowed after review of appeal/reconsideration.
   - W10 – No maximum allowable defined by fee guideline. Reimbursement made based on insurance carrier fair and reasonable reimbursement methodology. Paid per negotiated rate of $485.00 per diem
   - 97 – Payment is included in the allowance for another service/procedure. Included in revenue code 128

Findings

1. The insurance carrier reduced or denied disputed services with reason code W10 – "No maximum allowable defined by fee guideline. Reimbursement made based on insurance carrier fair and reasonable reimbursement methodology. Paid per negotiated rate of $485.00 per diem." The respondent's position statement asserts that "Since there is no allowable amount set by DWC for rehab facilities . . . negotiations are done with the facility as a matter of course to come to an agreement on reimbursement of their services. Since Paul Hymel, a representative of Sierra Providence agreed to accept $485.00 a day, TASB feels the agreement should be honored. . . . Documentation showing there was a statement by Paul Hymel of Sierra Providence that the SNF level was $485.00 a day is enclosed." Per Texas Business and Commerce Code §26.01, an agreement, promise, contract, or warranty of cure relating to medical care or results thereof made by a physician or health care provider is not enforceable unless the promise or agreement, or a memorandum of it, is in writing; and signed by the person to be charged with the promise or agreement or by someone lawfully authorized to sign for him. Review of the submitted information finds insufficient documentation to support that the disputed services are subject to a negotiated rate between the parties to this dispute. The above denial/reduction reason is not supported. The disputed services will therefore be reviewed for payment in accordance with applicable Division rules and fee guidelines.
2. This dispute relates to services subject to the provisions of former Texas Administrative Code §134.401(a)(2) which states that "rehabilitative inpatient admissions are not covered by this guideline and shall be reimbursed at a fair and reasonable rate until the issuance of a fee guideline on these specific types of admissions." The applicable rule for reimbursement of the disputed services is therefore found under former Texas Administrative Code §134.1, effective May 2, 2006, 31 *Texas Register* 3561, which requires that, in the absence of an applicable fee guideline, reimbursement for health care not provided through a workers' compensation health care network shall be made in accordance with subsection §134.1(d) which states that "Fair and reasonable reimbursement: (1) is consistent with the criteria of Labor Code §413.011; (2) ensures that similar procedures provided in similar circumstances receive similar reimbursement; and (3) is based on nationally recognized published studies, published Division medical dispute decisions, and values assigned for services involving similar work and resource commitments, if available."
3. Additionally, disputed dates of service on or after March 1, 2008 are subject to the provisions of the version of 28 Texas Administrative Code §134.1, effective March 1, 2008, 33 Texas Register 626, which requires that, in the absence of an applicable fee guideline or a negotiated contract, reimbursement for health care not provided through a workers' compensation health care network shall be made in accordance with subsection 134.1(f), which states that "Fair and reasonable reimbursement shall: (1) be consistent with the criteria of Labor Code §413.011; (2) ensure that similar procedures provided in similar circumstances receive similar reimbursement; and (3) be based on nationally recognized published studies, published Division medical dispute decisions, and/or values assigned for services involving similar work and resource commitments, if available." The Division notes that 28 Texas Administrative Code §134.404 is not applicable to these services, as per §134.404(a)(1), that section applies to medical services provided in an inpatient acute care hospital with an admission date on or after March 1, 2008. As the admission date for the services in this dispute was prior to March 1, 2008, the applicable rule for reimbursement is §134.1.

4. Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.
5. 28 Texas Administrative Code §133.307(c)(2)(E), effective May 25, 2008, 33 *Texas Register* 3954, applicable to requests filed on or after May 25, 2008, requires that the request shall include "a copy of all applicable medical records specific to the dates of service in dispute." Review of the submitted documentation finds that the requestor has not provided copies of any medical records to support the services in dispute. The Division concludes that the requestor has not met the requirements of §133.307(c)(2)(E).
6. 28 Texas Administrative Code §133.307(c)(2)(G), effective May 25, 2008, 33 *Texas Register* 3954, applicable to requests filed on or after May 25, 2008, requires the requestor to provide "documentation that discusses, demonstrates, and justifies that the amount being sought is a fair and reasonable rate of reimbursement in accordance with §134.1 of this title (relating to Medical Reimbursement) when the dispute involves health care for which the Division has not established a maximum allowable reimbursement (MAR), as applicable." Review of the submitted documentation finds that:
   - The requestor's position statement asserts that "Pursuant to DWC Rule 134.401(c)(6)(A)(i)(iii), once the bill has reached the minimum stop-loss threshold of $40,000, the entire bill will be paid using the stop-loss reimbursement factor of 75%."
   - As stated above, The Division's former *Acute Care Inpatient Hospital Fee Guideline* at 28 Texas Administrative Code §134.401 is not applicable to the services in dispute. Per §134.401(a)(2), "rehabilitative inpatient admissions are not covered by this guideline and shall be reimbursed at a fair and reasonable rate until the issuance of a fee guideline on these specific types of admissions." Therefore, the applicable rule for reimbursement is found under §134.1.
   - The Division has previously found that a reimbursement methodology based upon payment of a percentage of a hospital's billed charges does not produce an acceptable payment amount. This methodology was considered and rejected by the Division in the adoption preamble to the Division's former *Acute Care Inpatient Hospital Fee Guideline*, which states at 22 *Texas Register* 6276 that:

     "A discount from billed charges was another method of reimbursement which was considered. Again, this method was found unacceptable because it leaves the ultimate reimbursement in the control of the hospital, thus defeating the statutory objective of effective cost control and the statutory standard not to pay more than for similar treatment of an injured individual of an equivalent standard of living. It also provides no incentive to contain medical costs, would be administratively burdensome for the Commission and system participants, and would require additional Commission resources."

     Therefore, a reimbursement amount that is calculated based upon a percentage of a hospital's billed charges cannot be favorably considered when no other data or documentation was submitted to support that the payment amount being sought is a fair and reasonable reimbursement for the services in dispute.
   - The requestor did not submit documentation to support that payment of the amount sought is a fair and reasonable rate of reimbursement for the services in this dispute.
   - The requestor did not submit nationally recognized published studies or documentation of values assigned for services involving similar work and resource commitments to support the requested reimbursement.
   - The requestor did not support that payment of the requested amount would satisfy the requirements of 28 Texas Administrative Code §134.1.

   The request for additional reimbursement is not supported. Thorough review of the documentation submitted by the requestor finds that the requestor has not demonstrated or justified that payment of the amount sought would be a fair and reasonable rate of reimbursement for the services in dispute. Additional payment cannot be recommended.

Conclusion

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation does not support the reimbursement amount sought by the requestor. The Division concludes that this dispute was not filed in the form and manner prescribed under Division rules at 28 Texas Administrative Code §133.307. The Division further concludes that the requestor failed to support its position that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the services in dispute.

Authorized Signature

	Grayson Richardson	January 9, 2013
Signature	Medical Fee Dispute Resolution Officer	Date
Signature	Medical Fee Dispute Resolution Manager	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.